Yukon
Justice

FOR PUBLIC RELEASE: Coroner Judgement of Inquiry and Inquest Inquisition and Recommendations

Department of Justice, Legal Services
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Yukon Coroners Service: Judgement of Inquiry into the death of: Robin Charlie Sam

Coroner Investigative File No.: 45202013055

Name: Robin Charlie Sam Date of Birth: 1980/09/08 (YYYY/MM/DD) Date of Death: 2014/01/13 (YYYY/MM/DD)

Address: House 44, Pelly Crossing, Yukon (Street Address)

Ethnic Origin: First Nations Location of Death: Two Mile Hill in Whitehorse, South Side (Province/Territory, Postal Code)

Cause of Death

Hypothermia due to Exposure to Cold Environment.
Part II Contributory Factors: Generalized Seizure Disorder (by clinical history)

Manner of Death

Accidental

Autopsy Findings

An autopsy was performed on the body of Robin Sam on January 16, 2014 at Vancouver General Hospital by Dr. Carol Lee, Forensic Pathologist.

The autopsy noted scattered gastric mucosal hemorrhages and no apparent major anatomic pathology or injuries. The body of Mr. Sam was described as well-nourished and of average build. The autopsy showed no apparent anatomically evident fatal natural diseases or injuries.

Toxicological Findings

Toxicological analysis determined that there was no alcohol or illicit drugs detected in the post-mortem samples of Mr. Sam. Toxicological analysis showed phenytoin (3.80mg/L) in the post mortem blood, and acetone (0.02%) in postmortem urine. Blood levels of phenytoin (Dilantin) were below levels considered therapeutic in living patients.

Circumstances of Death

Mr. Sam was under Disposition of Yukon Review Board. He was required to take medication to control his generalized seizure disorder. The Disposition required that if any member of the treatment team became aware that Mr. Sam was not taking his medication for any significant amount of time, that they would notify all parties and Yukon Review Board "forthwith." The daily and monthly monitoring of his medication was not performed. Mr. Sam suffered multiple seizures requiring him to be hospitalized in October 2013. In October 2013 it was clearly documented that Mr. Sam was not taking his medication as directed. Mr. Sam also told his support workers that he was not taking his medication.

On January 10, 2014, Mr. Sam was in Whitehorse for an annual review hearing. He was disorientated, frightened, moaning, rocking back and forth, and clenching his fists. Mr. Sam left the hearing shortly after it began and could not be subsequently located.

Mr. Sam was found deceased at 3:21pm on January 13, 2014 on the south side of the Two Mile Hill in Whitehorse. The weather for January 10-12, 2014 ranged from -10C to -26C. Mr. Sam was not dressed appropriately for a prolonged exposure to the cold weather.

Significant Factors/Conclusions

Mr. Sam was required to take medication to control his seizure disorder. Daily monitoring and monthly blood work was not performed. He was hospitalized for seizures and it was documented that he was not compliant with his medication.

No one ensured that Mr. Sam was checked on daily. No one ensured that the monthly blood levels of the anti-seizure medication was performed.

No one informed the parties or Yukon Review Board "forthwith" that Mr. Sam was not taking his medication.

A generalized seizure disorder, when symptomatic and not well controlled, can predispose one to, or impair one's ability to escape from, life threatening environments/situations such as exposure to cold weather.

The pathologist determined that Mr. Sam's generalized seizure disorder contributed to his death.

Recommendations

TO: HEALTH AND SOCIAL SERVICES, GOVERNMENT OF YUKON

1. Ensure that all terms and conditions of a Yukon Review Board Disposition, within the authority and responsibility of the Director, Social Services or a delegated agent, are vigorously monitored for compliance and that all breaches or change in circumstance that require notification to all parties and/or the Board are made forthwith.

2. Implement a robust process for oversight of all delegated authority and/or responsibility and require regular ongoing reporting, monitoring, and written documentation evidencing how the delegated authority and/or responsibility is being fulfilled and meeting the needs of the client.

MacDonald
Signature, Chief Coroner

Whitehorse
Province/Territory

March 20/15
Date

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